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Issue Date: 02 February 2005

Case No.: 2003-LHC-2926

OWCP No.: 07-160271

In the Matter of

BENNIE HUNTER,
Claimant

vs.

DANOS & CUROLE MARINE CONTRACTORS, INC.,
Employer

and

THE GRAY INSURANCE COMPANY,
Carrier

DECISION AND ORDER

PROCEDURAL STATUS

This is a claim for benefits under the Longshore and Harbor Workers Compensation Act (the Act)[1] brought by Bennie Hunter (Claimant) against Danos & Curole Marine Contractors, Inc.(Employer) and Gray Insurance Co.(Carrier).

The case was referred to the undersigned Administrative Law Judge for hearing. Both parties were represented by counsel. On 8 Oct 04, a hearing was held at which the parties called witnesses, examined and cross examined those witnesses, offered exhibits, and made arguments. Post hearing briefs were submitted by both parties.

My decision is based upon the entire record which consists of the following[2]

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[1] 33 U.S.C. § 901 *et seq* (2001)

[2] I have reviewed and considered all testimony and exhibits admitted into the record. Reviewing authorities should not infer from my specific citations to some portions of witness testimony and items of evidence that I did not consider those things not specifically mentioned or cited.

Witness Testimony of
Steven LeBlanc

Exhibits
ALJ Exhibit 1 (Stipulation)
Claimant's Exhibits (PX) 1-5[3], 7-16[4]
Employer Exhibits (EX) 1-20

STIPULATIONS[5]

The parties stipulate and I find as fact:

1. Jurisdiction is proper, Claimant was engaged in maritime employment, Employer is a maritime employer, there was an employer/employee relationship at the time of the injury, and Claimant meets situs/status requirements.
2. The date of the injury was 19 Apr 01.
3. Employer was advised of the injury on 20 Apr 01.
4. Controversion was filed on 5 Jul 01, 7 Sep 01, 1 Oct 01, 1 Nov 01, and 20 Nov 01.
5. An informal conference was held 30 Aug 01 and 31 Oct 01.
6. Average weekly wage at the time of injury was $710.68; compensation rate was $473.78.
7. Salary was continued post injury in the amount of $4,368.20.
8. Disability at a rate of $473.78 was paid for a total of $8,460.32.
9. Some medical benefits have been paid.

FACTUAL BACKGROUND

On Thursday, 19 Apr 01, Claimant was working for Employer as a rigger on the Exxon Hoover Diana, a platform located off the coast of Texas, in Alamo Canyon Block 25. In the course of his work, he was stepping over some pipes and slipped and twisted his right foot in a deck penetration. A co-worker helped him to a space on the platform where there was a medical kit. He was experiencing pain in his right ankle so they sprayed it with an analgesic.

The next day Claimant's foreman noticed Claimant limping and asked him why. Claimant responded that he had twisted his ankle. The foreman explained that he should have reported the injury sooner. Claimant was not showing any signs of being in acute

[3] PX-6 is a deposition of Claimant done in preparation for a civil action in federal court. The parties agreed it was submitted in error and that EX-20 is the correct deposition.
[4] Although Claimant's exhibit index indicates PX-10 is a 1 Nov 01, report by Dr. Phillips, the submitted document is dated 27 Sep 01. Claimant indicated he would be submitting additional medical records, but later served notice that he did not need to do so.
[5] ALJX-1

pain, but since the ankle was swollen, the off-shore medic recommended Claimant be evaluated ashore. The foreman arranged for Claimant to travel on the regular crew change helicopter and be taken to Galveston Medical Center.

Claimant presented to the Emergency Department of University of Texas Medical Branch in Galveston on 20 Apr 01. He reported that his right foot had fallen into a hole the previous day and that he had pain in his right ankle. He was able to bear weight on the ankle with a limp. The assessment revealed swelling but no loss of feeling or function. X-rays of the right foot/ankle were ordered. They were read as showing soft tissue swelling but no fractures. The diagnosis was right ankle sprain. Claimant was prescribed Vicodin, an ankle splint for 10 days, crutches for 3 days and released for work with a no weight bearing/on crutches restriction through 24 Apr 01. He was told to return in 10 days if not pain free.[6]

Since it would be unsafe to have Claimant return to the rig on crutches, he was taken to Morgan City, where his fiancé could help care for him. Employer offered Claimant light duty, and on the following Monday (23 Apr 01) he drove from Morgan City to Employer's offices in Larose. However, when Employer saw Claimant's condition, they drove him back to Morgan City. It was then that Employer took the prescription for Vicodin and had it filled for Claimant. He has not returned to work for Employer since then.

On 25 Apr 01, Claimant was sent by Employer to see Doctor Margiotti, an orthopedist in Cut Off. He complained of foot and ankle pain. He also complained of numbness down the leg when he would put it down. Doctor Margiotti did not find any swelling and believed the degree of pain Claimant described should have been accompanied by some swelling or bruising. She did X-rays which did not indicate any fractures or severe ligament tears. She diagnosed an ankle sprain and prescribed Ibuprofen, an air cast, and general exercises and soaks. She cleared Claimant to return to work "as directed". She had worked with Employer regularly and they understood that to mean consistent with her diagnosis and Claimant's limitations.[7]

On 1 May 01, Claimant presented to Doctor Bourgeois' clinic in Morgan City. He provided a history of the accident and said he had injured his right ankle. Doctor Bourgeois examined Claimant and had X-rays taken. The X-rays were read as normal. Doctor Bourgeois diagnosed ankle sprain, prescribed an ankle splint, Vioxx, and Tylenol. He released Claimant to light duties with no prolonged standing, excessive walking, or climbing ladders. He directed Claimant to return to the clinic in a week.[8]

[6] EX-7
[7] EX-3-4
[8] EX-6

On 8 May 01, Claimant returned to Doctor Margiotti. He related pain and tenderness in the same areas and stated that he felt that he had made no progress. Doctor Margiotti prescribed therapy and a Medrol dose pack, and scheduled a re-evaluation in two weeks. Initially, she again cleared Claimant to return to work as directed, but changed her mind and put him on no-work status until she had a chance to further evaluate the injury. [9]

Between 9 and 21 May 01, Claimant attended 6 physical therapy sessions in Morgan City. He presented complaining of ankle pain, swelling, decreased range of motion and inability to bear weight. The therapist found very mild swelling (approx. 3% by volume), tenderness, and very limited active range of motion, including some self limiting motion. The course of treatment included ultrasound, whirlpool, heat and exercise. Upon his last session, Claimant reported no reduction in pain or improvement in motion. The therapist believed Claimant to either have a very low tolerance for pain or to be self-limiting his movement.[10]

On 14 May 01, Claimant called Doctor Margiotti's clinic to complain that his pain medications were not working and that he cancelled physical therapy because of the pain. He was given a prescription for Tylenol 3.[11]

On 22 May 01, Claimant returned to Doctor Margiotti. He said he had had no improvement and was still unable to put full weight on his right foot. He also complained of swelling at home. However, he presented using one crutch and was actually putting weight on his right foot. Upon examination Doctor Margiotti observed that he had better movement in his right foot than his left. She also did not find any swelling, even after an hour in the office with the foot either down or used in ambulation. In order to try to resolve the discrepancy between the objective and subjective aspects, Doctor Margiotti ordered an MRI. Claimant never returned to Doctor Margiotti.[12]

On 25 May 01, an MRI was performed on Claimant's right ankle. The report indicated a suspected fracture of the mid body of the talus with minimal deformity. It recommended clinical corroboration.[13]

[9] EX-3-4
[10] EX-5
[11] EX-3-4
[12] *Id*
[13] EX-4, p.2

Sometime before 15 Jun 01, Claimant retained an attorney. The attorney sent him to the Lafayette Bone and Joint Clinic. He presented there and complained of current symptoms that included lower right back pain and tingling aggravated by standing, numbness in right leg, ankle and foot, and spasms and throbbing in the right leg. He stated that the symptoms started on the date of the accident.[14]

On 14 Jun 01, and again on 5 Jul 01, Employer sent Claimant letters asking him to return to work for light duties.[15]

On 21 Jun 01, Claimant was seen by Doctor Blanda at the Lafayette clinic. On exam, he found Claimant to have tenderness in the right lumbosacral area, and right leg pain and weakness secondary to ankle and foot pain. Doctor Blanda ordered x-rays which he reported as showing a healed fracture of the right talus, transitional S1-2 vertebrae with a butterfly vertebra on the left, and a questionable irregularity of the hips and ischium. He prescribed no work and pain/sleep medications. He also ordered a bone scan and lumbar MRI.[16]

On 11 Jul 01, an MRI and bone scan were performed. The lumbar MRI indicated minor central soft tissue ridging and desiccation but no evidence of nerve root compromise. The bone scan of the back and feet were normal.[17]

Claimant returned to Doctor Blanda on 27 Sep 01, complaining that his right leg would give out, making him use a cane or crutches. He also stated that he had a feeling of burning and tightness along the ankle. Doctor Blanda's examination showed slight weakness in the right leg and tenderness along the knee. Doctor Blanda recommended physical therapy for the lower back three times per week and EMG/NCV of the right leg. He prescribed pain and sleep medications. That was Claimant's last visit to the Lafayette Clinic.[18] After an initial disagreement of the location of the treatment and an informal conference, employer paid for the treatment with Doctor Blanda.[19]

On 1 Nov 01 Claimant's attorney sent him to be evaluated by Doctor Phillips at the Louisiana Clinic in New Orleans. Claimant did not ask Employer or Carrier for permission to be seen at the Louisiana Clinic, ask Employer or Carrier to pay for his treatment at the Louisiana Clinic, or even inform Employer or Carrier that he was going to the Louisiana Clinic.

[14] PX-13
[15] EX-9
[16] PX-13
[17] EX-15
[18] PX-13
[19] EX-11

When Claimant presented to Doctor Phillips he complained of the following: constant and severe low back pain radiating into the right hip and foot along with burning, numbness, cramping and tingling; weakness in the legs; intermittent cervical pain occasionally radiating into the right shoulder and arm with numbness and tingling into the right hand; headaches, dizziness, and blurred and spotted vision; right knee pain including locking and giving way; and bowel, erectile and bladder problems. Doctor Phillips' report indicates that Claimant was unable to dress or undress without assistance and required crutches to walk. He took a series of X-rays. Doctor Phillips found evidence of a lumbar disc herniation. Doctor Phillips reported an abnormal lumbar exam, abnormal right foot exam, abnormal right knee. He diagnosed Claimant as a man with a useless right lower extremity, a total disability, and a poor prognosis. His treatment plan called for more imaging diagnostics and a general review of the case. He ordered an MRI of the knee, which was done on 19 Nov 01.[20]

Employer asked Claimant to be evaluated by Doctor Sweeney. Eventually he complied with that request. On 5 Nov 01, Claimant was examined by Doctor Sweeney. He examined Claimant and had x-rays taken. He also reviewed records from Doctor Margiotti, Doctor Blanda, Doctor Bourgeois, physical therapy, and the initial hospital visit in Galveston. While, based on the MRI, he allowed for the possibility of a talus fracture, the x-rays showed no pathology. His impression was that there was a paucity of objective findings that would support Claimant's subjective complaints. He concluded that Claimant sustained no back injury from his initial slip and fall and should be able to drive, dress, and ambulate without crutches.[21] Following the appointment with Doctor Sweeney, Claimant had no further contact with Employer or Carrier for an extended period.

On 9 Nov 01, Claimant's attorney sent him to be examined by Doctor Anastasio, a psychiatrist. Claimant provided a history that included hallucinations, hearing voices, suicidal and homicidal thoughts, and fantasizing about taking revenge on carrier. He continued treating with Doctor Anastasio through 2003. [22]

For the next 9 months, Claimant was treated by the Louisiana Clinic.

On 6 Dec 01, Doctor Phillips again saw Claimant, who reported no improvement. Doctor Phillips' review of the previous MRI of the back was insufficient to make a diagnosis, so he ordered a discogram and post discogram CT, along with an EMG. He had also reviewed the previously ordered MRI of his knee, which did not reveal any specific abnormalities.[23]

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[20] PX-10
[21] EX-2, p.1-3.
[22] PX-16
[23] PX-9

On 23 Jan 02, Claimant returned to the clinic asking for pain and sleep medications. He complained of being under a lot of stress and stated he was being seen by a psychiatrist, who had prescribed additional medications.[24]

On 29 Jan 02, Claimant underwent an EMG to rule out right lower extremity nerve pathology and right lumbosacral radiculopathy. The test was interpreted as strongly suggestive of a right S1 radiculopathy, but cautioned that Claimant was jumpy and sensitive and poor effort can obscure pathology.[25]

On 14 Feb 02, Claimant returned to Doctor Phillips. Doctor Phillips indicated the discogram had indicated an abnormality at 4-5.[26] Doctor Phillips's plan was to treat the back problem first with surgery and then evaluate the right extremity.[27]

On 26 Mar 02, Claimant returned to the clinic. He continued to demonstrate limited motion and stiffness in the right knee and ankle. A sprained ankle was diagnosed. He also had psychiatric problems and pneumonia, so was told to return to the clinic in a month.[28]

On 16 Apr 02 Claimant was seen at the clinic. His symptoms were unchanged and he was told to return in a month.[29]

On 25 Apr 02, Claimant was evaluated by Doctor Laborde. He also reviewed Claimant's May 2001 MRI, November 2001 x-ray, May 2001 x-ray, June 2001 x-ray, July 2001, bone scan and July 2001 MRI. Doctor Laborde found no objective support for Claimant's subjective complaints and no indication compelling surgical intervention.[30]

On 5 May 02, Claimant underwent lumbar fusion surgery.[31]

On 30 May he visited the clinic complaining of moderate to severe pain and continued problems in the right ankle. He was prescribed stronger pain medication and given an exercise regimen.[32]

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[24] *Id*
[25] *Id.* The results of the EMG, in any event, were also consistent with aging. *See* EX-8, p.6
[26] The abnormality at L4-5 was consistent with degenerative disc disease. *See* EX-2, p.6
[27] PX-9
[28] *Id*
[29] *Id*
[30] EX-8
[31] PX-11
[32] PX-9

On 27 Jun 02, he returned to the clinic with low back and left flank pain. He had mild ankle swelling and motion restriction, but was able to bear full weight. An ankle x-ray showed no signs of fracture or arthritis. The prognosis was good and no tests or consults were deemed necessary. He was told to return in 2 months.[33]

During this period, Claimant was pursuing a civil lawsuit against Employer and Exxon. In April and May 2002, Dr. J.M. Laborde examined Claimant, reviewed records, and sent his reports to attorney Louise White. Those reports were eventually received by Carrier on 3 Jun 02. They indicated that Dr. Laborde didn't believe surgery was appropriate at that time.

As part of the discovery Carrier and Employer received medical records showing that Claimant had been treated and operated upon at the Louisiana Clinic. Neither Carrier nor Employer knew about the Louisiana Clinic course of treatment until after the surgery was complete.

In June 2002, as part of the discovery process for the civil suit, Claimant was twice seen by Doctor Hannie, a clinical psychologist. He did a comprehensive records review to include medical records, prison records and the depositions in the case. He then administered multiple psychological tests and obtained a history. He found that one test indicated Claimant's complaints of pain were valid and consistent with the back surgery done a few weeks prior to the examination. He also found strong indications of malingering and feigning psychological symptoms.

ISSUES

This case is primarily a factual dispute involving a fundamental and basic disagreement as to the nature and extent of Claimant's injury. A secondary issue relates to whether Claimant failed to seek Employer approval before obtaining treatment.

Past Medical Treatment

Claimant seeks payment for medical expenses incurred in treatment at the Louisiana Clinic. Employer responds that such treatment was obtained without its knowledge. Employer also argues that the treatment was neither necessary nor related to any injury suffered in the course of employment.

[33] *Id*

Future Medical Treatment

Claimant seeks to have Employer provide ankle and knee surgery. Employer argues that the treatment is neither necessary nor related to any injury suffered in the course of employment.

Existence and Degree of Disability

Claimant seeks total disability. Employer argues that suitable alternative employment was offered but refused and that in any event, Claimant no longer suffers from any covered injury that impacts his wage earning ability.

APPLICABLE LAW

In the absence of any substantial evidence to the contrary, the Act presumes that a claim comes within its provisions.[34] The presumption takes effect once the claimant establishes a *prima facie* case by proving that he suffered some harm or pain and that a work related condition or accident occurred which could have caused the harm.[35]

Once the presumption applies, the burden is on the employer to go forward with substantial countervailing evidence to rebut the presumption that the injury was caused by the claimant's employment.[36] Once an employer offers sufficient evidence to rebut the presumption, it is overcome and it no longer controls the result.[37] If the presumption of compensability is successfully rebutted, the presumption no longer affects the outcome of the case. The fact-finder must then weigh all the evidence in the record and resolve the fact at issue based on the evidence.[38]

However, the presumption does not apply to the issue of whether a physical harm or injury occurred,[39] does not aid the claimant in establishing the nature and extent of disability,[40] and is not applicable to the issue of the claimant's loss of wage-earning capacity.[41]

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[34] 33 U.S.C. § 920(a)(2001)
[35] Gooden v. Director, OWCP, 135 F.3d 1066 (5th Cir. 1998)
[36] Swinton v. J. Frank Kelly, Inc., 554 F.2d 1075, 1082 (D.C. Cir. 1976), cert. denied, 429 U.S. 820 (1976)
[37] Noble Drilling Co. v. Drake, 795 F.2d 478 (5th Cir. 1986)
[38] *Id.*
[39] Devine v. Atlantic Container Lines, G.I.E., 25 BRBS 15 (1990)
[40] Holton v. Independent Stevedoring Co., 14 BRBS 441 (1981); Duncan v. Bethlehem Steel Corp., 12 BRBS 112 (1979)
[41] Leach v. Thompson's Dairy, Inc., 13 BRBS 231 (1981)

A claimant must establish that the medical expenses are related to a compensable injury.[42] A qualified physician indicating treatment was necessary for a work-related condition establishes a *prima facie* case for compensable medical treatment.[43] An employer is not liable for medical expenses due to the degenerative processes of aging.[44]

The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.[45] However, the care must be appropriate for the injury.[46]

Claimants who pay for their own treatment without first requesting that the employer provide it risk losing compensation.

> An employee is not entitled to reimbursement of money which he paid for medical or other treatment or services unless:
> (A) his employer refused or neglected to provide them and the employee has complied with subsections (b) and (c) and the applicable regulations, or
> (B) the nature of the injury required the treatment and services and, although his employer, supervisor, or foreman knew of the injury, he neglected to provide or authorize them.[47]

Before an employer can be said to have neglected to provide any medical treatment or care, there must have been a request for that care.[48] However, once the employer has refused to provide treatment or to satisfy a claimant's request for treatment, the claimant is released from the obligation of continuing to seek employer's approval.[49] The burden of establishing compliance or conditions justifying non-compliance is on the claimant.[50]

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[42] Pardee v. Army & Air Force Exch. Serv., 13 BRBS 1130 (1981)
[43] Turner v. Chesapeake & Potomac Tel. Co., 16 BRBS 255 (1984)
[44] Haynes v. Rederi A/S Aladdin, 362 F.2d 345 (5th Cir. 1966), cert. denied, 385 U.S. 1020 (1967)
[45] 33 U.S.C. § 907(a); 20 C.F.R. § 702.402
[46] Ballesteros v. Willamette Western Corp., 20 BRBS 184, 187 (1988)
[47] 33 U.S.C. § 907(d)(1) (2001); 20 C.F.R. § 702.421(2004)
[48] Jackson v. Navy Exch. Serv. Center, 9 BRBS 437 (1978)
[49] Pirozzi v. Todd Shipyards Corp., 21 BRBS 294 (1988)
[50] Maryland Shipbuilding & Drydock Co. v. Jenkins, 594 F.2d 404 (4th Cir. 1979)

In evaluating evidence, the ALJ must determine the credibility and weight to be attached to the testimony of the medical witnesses and is entitled to deference in doing so.[51] Generally, the opinion of a treating physician is entitled to greater weight than the opinion of a non-treating physician.[52]. However, an ALJ is not bound by the opinion of one doctor and can rely on the independent medical evaluator's opinion and evidence from the medical records over the opinion of the treating doctor.[53]

A claimant's criminal record and history of lying may be relevant to claimant's trustworthiness as a witness[54] or if in diagnosing the claimant's condition, doctors relied on what the claimant told them.[55]

EVIDENCE

Nature and Extent of Injury

The most probative evidence relating to the nature and extent of Claimant's injury consists of his deposition, the deposition of Roland Lafont, medical records and reports, and expert medical testimony of Doctor Margiotti and Doctor Sweeney by way of deposition.

CLAIMANT'S DEPOSITION[56]

Claimant testified that:

His right foot slipped into a deck penetration and made him fall. His right foot started swelling and was in acute pain. He felt no other pain or discomfort at the time. That evening, he sought out Roland Lafont and told him what happened. Lafont filled out a report. After treatment in the transport and emergency treatment in Galveston, he saw Doctor Margiotti and complained to her of numbness in his back and arm and tingling down his leg. Doctor Margiotti did an X-ray and ordered an MRI.

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[51] John W. McGrath Corp. v. Hughes, 289 F.2d 403 (2nd Cir. 1961); Pimpinella v. Universal Maritime Service, Inc., 27 BRBS 154 (1993)
[52] Downs v. Director, OWCP, 152 F.3d 924, (9th Cir. 1998); *see also* Loza v. Apfel, 219 F.3d 378 (5th Cir. 2000)(Social Security administrative law decision)
[53] Duhagan v. Metropolitan Stevedore Co., 31 BRBS 98 (1997)
[54] *cf* FRE 608(b)
[55] Houghton v. Marcom, Inc., (BRB Nos. 99-0809 and 99-1315)(April 25, 2000)(Unpublished)
[56] EX-20

He first complained of back and knee pain to Dr. Cobb and Dr. Blanda, but can't recall when he first experienced those symptoms. His attorney didn't suggest that he go to Dr. Cobb and Dr. Blanda. He picked them out of the phone book on the suggestion of his brother-in-law. He was told to go to them. He left their clinic "because the surgeries and stuff he diagnosed that was wrong."[57] They told him they couldn't perform the surgery he needed and he should go to another doctor who could do the surgery.

He did not go to the Louisiana Clinic on the advice of his attorney but was directed there by the doctors. He never asked Employer or Carrier to pay for treatment at the Louisiana Clinic. The treatment there was covered by his group health plan. He was treated by the Louisiana Clinic doctors. Doctor Watermeier recommended back surgery and at the same time said Claimant needed knee surgery and that his ankle needed to be re-broken and screwed back together. He couldn't continue with the Louisiana Clinic because his insurance ran out.

After the back surgery, he continued to have pain and was treated by Dr. Haydel, a pain specialist. He can't recall the exact date he began seeing Dr. Haydel, but he has been seeing him for quite a while. The treatment includes pain medications and hip and spine injections and is covered by both Medicare and Medicaid.

He was in a wheelchair but then went to a walker, crutches, and now uses a cane. He has a tendency to fall. He can't stand for long because both feet swell. He has pain in the donor site from which bone was taken for the fusion.

He doesn't remember asking to see a psychiatrist in prison because he was hearing voices and seeing green children's faces attacking him. He doesn't recall saying he has lower back problems from a birth defect. He doesn't have a back birth defect. He has never used drugs other than prescribed medications. Sometimes in prison you have to lie to get any attention. He continues to have severe pain in his back, ankle, and knee, along with numbness, in the right fingers and arm and headaches.

ROLAND LAFONT'S DEPOSITION[58]

Roland Lafont testified that:

He was Claimant's foreman on the rig. He first became aware of Claimant's injury the day after the accident. He saw Claimant limping and asked him what happened. Claimant said he twisted his ankle. He took Claimant to the medic who said the injury should have been seen the day before. By then it was so swollen it would need to be evaluated at a hospital.

[57] *Id* p.50
[58] EX-17

DR. MARIE MARGIOTTI'S DEPOSITION[59]

Dr. Marie Margiotti testified that:

For a short period immediately following the accident, she was Claimant's treating orthopedist. On examination six days post trauma (25 Apr 01), she found no swelling, motor or sensory deficits, or instability. She would have expected to see more swelling or bruising, based on the pain reported by Claimant. She ordered and reviewed x-rays, which showed no fractures or severe ligament damage. She diagnosed an ankle sprain and gave him an air cast and Ibuprofen.

He returned on 8 May 01 and reported no improvement. She could find no objective reason for the pain, so she prescribed physical therapy. When he returned on 22 May 01, he again reported no improvement, in spite of the physical therapy. He complained that he could not put his full weight on his right foot and was using one crutch. She told him that by using one crutch he was in fact putting weight on the right foot. On examination, he had less range of motion in his left leg than the right. Contrary to his complaints, she observed no swelling, even with the right foot lowered for an extended period. Although she suspected symptom magnification she ordered an MRI. She never saw Claimant again.

She did not personally read the 25 May 01 ankle MRI, but reviewed the report. Had she continued to see Claimant, and based on the MRI report she would have kept him non-weight bearing for six to eight weeks. Even assuming that there was a fracture, Claimant should have experienced minimal, if any residual problems.

Since then she has also reviewed Dr. Sweeny and Dr. Laborde's reports. She believes that a subsequent negative bone scan indicates that the MRI reading was incorrect and there was no fracture. Her opinion is that there was no fracture but symptom magnification. With the low severity of the sprain she would have expected a maximum recovery period of 12 weeks.

She has reviewed the records relating to Claimant's back surgery. She believes that any back problems were age-related degeneration. If the accident on the rig aggravated or accelerated those problems she would have expected to see it in the month she was his treating doctor. Consequently, her opinion is that any back problems are unrelated to the accident on the rig.

[59] EX-3

It is her habit to exam the knee, at least for range of motion, when she examines the ankle. She noted no problems and Claimant made no complaints about the knee.

DR. JOHN SWEENEY'S DEPOSITION[60]

Dr. John Sweeney testified that:

He is an orthopedist, but was never Claimant's treating doctor. He twice evaluated Claimant, once in November 2001 and once in May 2004. During the 2001 examination, he took a history and Claimant told him he was sent to Dr. Phillips by his attorney. Claimant said Dr. Phillips found torn ligaments in his knee and problems with his back. He also reviewed records from Doctor Blanda, Doctor Margiotti, the Galveston hospital visit, the ankle MRI, and physical therapy. He conducted an examination and number of tests which indicated to him that Claimant was intentionally minimizing his range of motion, not cooperating in the examination, and magnifying symptoms. His opinion at that time was that there was no ankle fracture, and no back injury other than possible age-related degeneration.

In May of 2004, he again examined Claimant and reviewed the records of other treating and evaluating doctors. He took an additional history, during which Claimant told him that when he slipped and injured his ankle he also broke his kneecap and had to have a lumbar discectomy. He found nothing in any records to indicate a broken kneecap. He believed that Claimant was inconsistent, exaggerating and demonstrating specific detailed amnesia. On a scale of 1 to 10 Claimant rated his pain at a 12. He believed Claimant was magnifying his symptoms and was the least likely type of patient to benefit from surgery.

The tests he conducted disclosed no objective problems that would account for Claimant's complaints. The small differential in calf circumference could be attributable to disuse even in the absence of pathology.

He reviewed Dr. Phillips' records, including the notes from Claimant's 1 Nov 01 visit. He examined Claimant four days later. He found nothing that would support Dr. Phillips' diagnoses. There was no sacroiliac sublaxation, no evidence of a lumbar disc herniation, no torn anterior cruciate ligament, and no intertarsal sublaxation of the right foot. He has no clue as to how Doctor Phillips arrived at those conclusions.

[60] EX-1

Doctor Phillips's 6 Dec 01 note says Doctor Phillips agrees with the Jul 01 MRI report that there was disc herniation. However, that's not what the report says, and Doctor Phillips is actually disagreeing with the MRI report. None of the tests that Doctor Sweeney reviewed indicated anything other than degeneration, with the possible exception of the right radiculopathy on the EMG. However, that test is examiner dependent and the examiner reported poor cooperation by Claimant.

The operative report post surgery references a lumbar disc syndrome diagnosis, but did not report any traumatic pathology. In his opinion, the back surgery was unnecessary and unreasonable.

His review of the knee MRI and examination showed the knee to have no more than mild age-related degeneration of the cartilage beneath the kneecap. That was confirmed by a bone scan, which would have shown evidence of a fractured patella.

The bone scan also leads to the conclusion that the MRI of the ankle which was read to show a talus fracture was a false positive.

He reveiwed Doctor Hannie's reports and found it to be very consistent with findings and the findings he reviewed in reports by other providers.

His conclusion in November of 2001 was that Claimant had suffered an ankle sprain which had healed and that there was no reason he could not return to his pre-injury employment. As of today, there is no evidence that he had suffered an injury to his back or knee as a result of the April accident. His current employment may be limited by the fusion surgery, but if that were taken out of the equation, he could return to work.

MEDICAL RECORDS

20 Apr 01 visit to Galveston Hospital (20 Apr 01)[61]: Claimant gave history of twisted ankle and complained of ankle pain. He was able to bear weight but limping. Ankle was swollen. X-rays read as showing no fractures. Diagnosis was sprained ankle.

Doctor Margiotti treatment records (25 Apr 01, 8 and 22 May 01)[62]: Claimant complained of foot and ankle pain and leg numbness. X-rays were negative. No improvement over three visits and physical therapy. Left leg movement is worse than right leg. Claimant states he cannot put weight on right foot even though he is by using single crutch. Diagnosis was sprained ankle. MRI was ordered to rule out other causes of pain.

[61] EX-7
[62] EX-4

Doctor Bourgeois treatment records (1 May 01)[63]: Claimant gave history of twisted ankle and complained of ankle pain. X-rays were negative. Diagnosis was sprained ankle.

Physical therapy records (May 2001)[64]: Claimant gave history of twisting his foot and subsequent ankle pain. There was mild swelling. Claimant attended six sessions and reported no improvement. Assessment was that Claimant either has a very low pain tolerance or is self-limiting his movement.

May 2001 MRI of Ankle[65]: Apparent fracture of talus with minimal deformity, recommended clinical correlation.

Doctor Blanda Treatment Records (June-September 2001)[66]: Claimant gave history describing accident and complaining of lower right back tingling and pain and right leg and ankle numbness and throbbing. Claimant reported pain in right leg and back with 70 degree straight leg raise. Assessment was: negative for disc herniation, possible congenital abnormality.

July 2001 MRI of Lumbar Spine[67]: Minor central soft tissue ridging and desiccation at 4-5 and L5-S1 with no evidence of nerve root compromise.

July 2001 Bone Scan[68]: No abnormalities in lumbar spine or feet.

Louisiana Clinic Treatment Records (November – July 2001)[69]:

> (November 2001) Claimant presented complaining of constant and severe low back pain radiating into the right hip and foot along with burning, numbness, cramping and tingling; weakness in the legs; intermittent cervical pain occasionally radiating into the right shoulder and arm with numbness and tingling into the right hand; headaches, dizziness, and blurred and spotted vision; right knee pain including locking and giving way; and bowel, erectile and bladder problems. Claimant was unable to dress or undress without assistance and required crutches to walk. A series of X-rays was taken. Assessment: evidence of a lumbar disc herniation, sacroiliac sublaxation, torn anterior cruciate ligament, and sublaxation of right intertarsal joints.

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[63] EX-6
[64] EX-5
[65] EX-4 p.2
[66] CX-13
[67] *Id*
[68] *Id*
[69] PX-9,10.

(December 2001): Claimant stated back and leg pain continues. MRI of knee showed nothing specific. Reviewed July 2001 back MRI and found herniation.

(January 2002): EMG strongly suggestive of right S1 radiculopathy. Poor patient cooperation and relaxation made test less than ideal. Clinical and other diagnostic correlation recommended.

(February 2002): Visit notes reflect that a discogram showed an abnormal disc at 4-5.

(March 2002): Visit notes by Dr. Addato show diagnosis of sprained ankle/foot, sprained knee, and lumbar disc.

(April 2002): Notes show lumbar disc syndrome may require elective fusion surgery.

Evaluation/Reports by Dr. J.M. Laborde (April/May 2002)[70]: Physical examination of Claimant and review of his May 2001 MRI, November 2001 x-ray, May 2001 x-ray, June 2001 x-ray, July 2001, bone scan and July 2001 MRI. No findings to support Claimant's subjective complaints and no indication for surgery. Symptoms attributed to pre-existing conditions and psychological factors.

May 2002 Operative Report[71]: Bilateral lumbar arthrodesis performed at L3-4, L4-5. Post operative diagnosis: lumbar disc syndrome.

Doctor Anastasio Treatment Records (2001-2003)[72]: Claimant reported hallucinating, hearing voices, suicidal and homicidal thoughts, and fantasizing about taking revenge on carrier. Diagnosis: Major depressive disorder single episode moderate chronic and problems related to the social environment.

Doctor Hannie Evaluation and Report (June 2002)[73]: Conducted comprehensive records review, administered multiple psychological tests, and obtained a history. Found test to indicate that Claimant's complaints of pain were valid and consistent with recent back surgery. Found strong indication of malingering and feigning psychological symptoms.

[70] EX-8
[71] PX-11
[72] PX-16
[73] EX-19

Doctor Sweeney Evaluation and Report (November 2001)[74]: Took history, reviewed records, took ankle x-ray, and performed physical examination. X-ray was negative. Diagnosis: sprained right ankle/possible occult talus fracture. Assessment: No objective reason why Claimant cannot dress self or drive and only a congenital condition in the lumbar spine.

Doctor Sweeney Evaluation and Report (May 2004)[75]: Took history, reviewed records, and performed physical examination. Assessment: resolved right ankle sprain, no identifiable pathology in the knee or pain, no findings to support sacroiliac, knee or ankle surgery.

ANALYSIS

Nature & Extent of Injury

This issue ultimately rests on the credibility and reliability of Claimant's deposition and the medical evidence.

CLAIMANT'S DEPOSITION

Claimant's deposition has multiple statements that are confused, inconsistent and simply incorrect. For example, he maintains he sought out his foreman and reported the accident the day it happened.[76] The foreman's deposition[77], accident report[78], and even the stipulation[79] indicate that notice wasn't given until the day after the injury. Claimant stated he went to the Lafayette Clinic based on talking to a brother-in-law and looking in the phone book.[80] The history form he completed stated he was referred by "Atty Brad Andrus."[81]

Claimant stated that the doctors at the Lafayette Clinic told him he needed surgery, but they couldn't do it, so he should go to the Louisiana Clinic.[82] Neither Doctor Blanda's note[83] nor the clinic records[84] have any indication that they so advised him. Moreover the Carrier's claim representative testified that Doctor Blanda does that type of

[74] Ex-2 p.1
[75] *Id* p.4
[76] EX-20 p. 34
[77] EX-17 p.11
[78] *Id* p.25
[79] ALJX-1
[80] EX-20 p.47
[81] PX-13
[82] EX-20 p. 50.
[83] EX-14
[84] PX-13

surgery.[85] The letter written by Doctor Phillips after Claimant's first visit to the Louisiana Clinic is to Claimant's attorney and thanks him for the consultation.[86] It does not indicate that Doctor Blanda referred Claimant to perform surgery Doctor Blanda was unable to do himself.

Claimant specifically denied prior back problems, psychiatric problems, and having ever used cocaine.[87] His prison records indicate he had used cocaine, complained of back problems, and been treated for psychiatric problems. [88] He stated that in prison "you do have to say things that's not true to get attention."[89]

Claimant has been evaluated and treated by a number of mental health care providers. The prison records indicate Claimant was manipulative and claimed to have audio-visual hallucinations.[90] Doctor Anastasio's found that Claimant complained of hallucinations and suffered from a major depressive disorder. Doctor Hannie's assessment was that Claimant is likely malingering and feigning symptoms, including the hallucinations.[91]

Claimant's deposition is not a particularly reliable or credible source of evidence in the case and will not carry as much weight as the medical evidence. His credibility also affects the weight given to medical opinions that rely largely on the accuracy of his statements.

MEDICAL EVIDENCE

There is perhaps no better illustration of the stark conflict in the medical evidence in this case than the evaluations of Claimant by Doctor Sweeney[92] and Doctor Phillips.[93] They were but a few days apart and yet had markedly different findings. Doctor Phillips' assessments run contrary to those of other doctors in the case and appear to rely more on Claimant's complaints.

[85] TR. p.60
[86] PX-13
[87] EX-20 pp. 20, 26
[88] EX-12 pp.1, 4, 43,52
[89] EX-20 p.83
[90] EX-12 p. 52
[91] EX-19
[92] EX-2
[93] PX-10

The Ankle

There is no question that the ankle was injured in some manner in the scope and course of Claimant's employment. What is at issue is the degree of injury. The first treating doctor at Galveston conducted an examination and ordered x-rays which were negative for a fracture. He diagnosed a sprain.

The next treating physician was Doctor Margiotti, an orthopedist.[94] Doctor Margiotti saw Claimant for multiple appointments. She conducted physical examinations and took x-rays. The x-ray was negative and she diagnosed a sprain. She noted inconsistencies between Claimant's reported level of pain and mobility and her objective findings. Even though she suspected symptom magnification, she ordered an MRI in order to rule out any other unknown causes. She believes that even though the MRI showed evidence of a fracture, the subsequent negative bone scan is most determinative and the MRI reading was incorrect. Her opinion is that Claimant had an ankle sprain which would have a maximum recovery time of 12 weeks.

Doctor Bourgeois also saw Claimant for treatment. He likewise conducted an examination and did x-rays. The x-rays were negative. He diagnosed an ankle sprain.

Doctor Blanda, in the course of treating Claimant, reviewed earlier x-rays and found a questionable talus fracture. In x-rays he took he found a healed fracture. Prior to getting a bone scan his assessment was a healed broken talus with no arthritis. His post bone scan notes simply say that the x-rays showed a healed fracture and focuses on other issues.

Doctor Phillips, in his reading of the November 2001 foot and ankle x-ray makes no mention of a talus fracture, but mentions possible intertarsal or distal tibia and fibula problems. June 2002 x-rays were read by Doctor Watermeier as showing no fracture.

Doctor Sweeney, upon reviewing the records and examining Claimant concurs with Doctor Margiotti, Doctor Bourgeois, and the Galveston treating doctor that Claimant suffered an ankle sprain. Doctor Laborde found either a healed fracture or sprain.

While Section 20(a) provides for a presumption that an injury, once established, arose out of and in the course of employment, it does not apply to whether an injury occurred, or the scope of the injury.[95] However, even if it did, in this case Employer has

[94] Claimant's brief (at page 6) argues that DM is neither an orthopedist nor surgeon. It cites her deposition (EX-3 p. 51) in support of that proposition. However, all she said at point was that she did not specialize in occupational injuries. She in fact did her residency in orthopedic surgery, is a member of the Board and Academy of orthopedic surgeons and is an active practitioner in that area. (EX-3 p.8)

[95] *See* fn. 33-34, *supra*

provided substantial evidence to rebut any presumption that Claimant's ankle was broken. Moreover, the evidence clearly establishes that it is much more likely than not that Claimant suffered a sprained, but not a broken ankle.

That is the opinion of multiple doctors, including treating doctors. The opinion is based on and corroborated by the vast majority of the objective findings, from the degree of swelling and bruising to the imaging data. The x-rays, with some exceptions, disclosed no fracture. Even more significant was that the bone scan confirmed it. The contrary view evidence is based largely on an MRI reading, which itself recommended clinical corroboration, and the subjective complaints and history of Claimant, whose reliability is questionable.

The Back

Although Claimant mentioned some tingling and numbness in his leg to Doctor Margiotti, his first specific compliant about back pain was to Doctor Blanda, his treating doctor, in June, about two months after the accident. Doctor Blanda did x-rays and an MRI. He found minor soft tissue ridging and desiccation at 4-5 and L5-S1. He found no herniation but assessed a possible congenital abnormality.

Doctor Phillips, who actually treated Claimant through the period including the back surgery, states that he agrees with the radiologist that there is a herniation. However, the actual report does not mention a herniation. Doctor Phillips found that the discogram indicated an abnormality at 4-5 and the EMG indicated a right S1 radiculopathy.

Both Doctor Laborde and Doctor Sweeney, who examined Claimant and reviewed the records, disagreed with Doctor Phillips. They assessed the back abnormalities to be consistent with aging and not the result of trauma. Likewise, Doctor Margiotti, who reviewed the records but did not re-examine Claimant in regards to his back, assessed his back problems as associated with the normal aging process and unrelated to any trauma.

The operative reports from the fusion procedure do not include any indication that the surgeon found herniation or trauma related irregularities.

Contrary to the issue of the broken ankle, there is no significant issue as to the existence of some sort of back abnormality. The issue is whether it was caused by the accident on the rig. Claimant's evidence raises the Section 20(a) presumption. However, Employer has offered substantial countervailing evidence to rebut that and it no longer controls the result. I must weigh all the evidence in the record and resolve the fact at issue based on the evidence.[96]

[96] *See* fn. 35-37, *supra*

The evidence clearly establishes that it is more likely than not that the disk abnormalities were a result of congenital conditions and the natural aging process and degeneration rather than caused or aggravated by trauma.

Doctor Margiotti, Doctor Sweeney, Doctor Blanda, and Doctor Laborde disagree with Doctor Phillips' assessment and concur that any problems are not a result of the accident. The EMG was questionable because of Claimant level of participation. Both the EMG result and the discogram result are consistent with aging. Doctor Phillips's assessment appears to give great weight to the subjective symptoms reported by Claimant, notwithstanding objective test results, and his unreliability. More importantly, the operative report shows nothing that corroborates Doctor Phillips's assessment or rebuts the other doctors' opinions. Even allowing for the fact that Doctor Phillips was the most involved treating doctor, the clear weight of the evidence is that the only problems with Claimant's back were age and not job related.

The Knee

Doctor Margiotti wasn't looking for a knee problem when she examined Claimant, but regularly checks the knee when she examines the ankle. She found no abnormalities. Claimant's first specific reference to knee pain was during a visit to Doctor Blanda, months after the accident.

Doctor Phillips diagnosed an anterior cruciate ligament tear but subsequent imaging, including an MRI failed to confirm it. Filling in for Doctor Phillips, Doctor Addato diagnosed a knee sprain. Doctor Sweeney's examination of Claimant led him to believe Claimant was intentionally feigning symptoms relating to the knee. Neither Doctor Sweeney nor Doctor Laborde found anything in their examinations of Claimant to substantiate Doctor Phillips' assessment. Doctor Phillips does not address the knee in notes following Dr. Addato's assessment.

The initial issue as to Claimant's knee is not whether it was injured in the course of his employment, but whether it was injured at all. While Section 20(a) provides for a presumption that an injury, once established, arose out of and in the course of employment, it does not apply to whether an injury occurred, or the scope of the injury.[97]

The clear weight of the evidence is that there was no knee injury. Doctor Phillips's briefly mentioned assessment is unsupported by any imaging and uncorroborated by physical examinations conducted by other doctors. Once again, the assessment by Doctor Phillips seems to be primarily based on Claimant's reported

[97] *See* fn. 33-34, *supra*

subjective symptoms. Claimant is an unreliable source. Doctor Sweeney believed Claimant was attempting to mislead him as to his symptoms. Consequently, even given Doctor Phillips's status as a treating doctor in the case, the weight of the evidence clearly establishes that there was no knee injury.[98]

Failure to Request/Denial of Treatment[99]

The only direct evidence on this issue was the testimony of Steven LeBlanc.[100] Mr LeBlanc testified that he is employed by Carrier as a claims representative and was responsible for Claimant's case from the beginning. He stated that after Claimant's evaluation by Doctor Sweeney in November of 2001, Claimant "fell off the radar screen." Carrier heard no more from him until, as part of a Jones Act suit, it obtained medical records from Employer's attorney. Those records indicated Claimant had already had surgery on his back. Employer's attorney indicated to Mr. LeBlanc he was surprised to discover Claimant had had back surgery. Claimant never sought authorization for the treatment.[101]

In his brief, Claimant's counsel cites Doctor Laborde's April 2002 report,[102] which discusses the fact that Doctor Phillips is treating Claimant and recommending back surgery. It was provided to attorney Louise White, who represented Exxon, a co-defendant with Employer in the federal civil suit. Claimant further suggests that it would not be unreasonable to assume that the attorney for Employer (on the civil suit) would have received Doctor Laborde's report about the same time White received hers. Claimant therefore argues that Employer/Carrier can be assumed to have received the report on or about 30 Apr 02. I weigh the direct testimony of Mr. LeBlanc that he and the attorney first heard of Claimant treating with Doctor Phillips after the surgery more heavily than the circumstantial evidence argued by Claimant and determine that neither Employer nor Carrier had notice of the treatment with Doctor Phillips until after the surgery.

Claimant also points out that Doctor Sweeney's November 2001 report mentions Claimant reports being treated by Doctor Phillips for his back and that Carrier received the report on 19 Nov 01.[103] Claimant proposes that having received these two reports, Employer/Carrier was obligated to investigate and actively object to the treatment by Doctor Phillips.

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[98] However, even if the Section 20(a) presumption applied and was raised, Employer has provided substantial evidence to rebut the presumption and the weight of the same evidence in the case establishes that there was no connection between any knee condition and the Claimant's employment.
[99] The issue is moot in light of my findings on the nature and extent of injury, but I address it in the alternative.
[100] TR. pp 36-72
[101] TR p. 40-41,56
[102] EX-8 p.4
[103] EX-2 p.1

The legal issue raised by Claimant is straightforward. In this case, an employee was injured in a Longshore Act accident. After some medical treatment provided for by Employer, he ceased further contact with Employer and sought and received medical treatment on his own, without giving the employer the opportunity to provide it. He also filed a non-Longshore civil suit against Employer. In preparing for that litigation, Employer obtained medical records from other doctors which, while mentioning that Claimant was being treated by another doctor, questioned the need for the treatment.

Claimant's counsel suggests that under these facts, Employer had an affirmative obligation to more fully investigate the treatment and object to it. He cites one regulatory provision and three Board cases. None of them are applicable to this case.[104] I find no statutory, regulatory, or case law authority that would extrapolate from these facts a constructive denial of a request from Claimant to pay for the treatment with Doctor Phillips and satisfy Section 7(d).

Disability

Doctor Margiotti stated that the maximum recovery period for the ankle injury suffered by Claimant should have been twelve weeks.[105] On 1 May 01, Doctor Bourgeois cleared Claimant to return to light duties.[106] Shortly thereafter, Doctor Margiotti originally returned him to work, but then changed her mind and put him in a no-work status until she could resolve his unexplained complaints.[107] That had not changed when Claimant quit seeing Doctor Margiotti, retained an attorney and began treating with Doctor Blanda and then Doctor Phillips.

Doctor Blanda continued the no work status.[108] Doctor Phillips determined on 1 Nov 01 that Claimant was totally disabled. Four days later, Doctor Sweeney examined Claimant and while not specifically addressing work disability, found no reason Claimant could not walk normally, dress himself, or drive, in spite of Claimant's protestations that he could not.[109]

The restrictions placed on Claimant's work by Doctor Blanda and Doctor Phillips were clearly based on more than the ankle sprain he suffered on the job. Because Claimant continued to be unable or unwilling to work after his work related injury healed it is difficult to set a time frame for the disability attributable to the covered injury.

[104] 20 CFR 702.338 pertains to the duties of an ALJ at a formal hearing to fully inquire into issues; Gray & Co. v. Highlands Ins. Co., 9 BRBS 242 (1978) and Camporeale v. Pittston Stevedoring Corp. 8 BRBS 297 (1978) both deal with notice of injury as it relates to Section 13 statute of limitations; Sprague v. Bath Iron Wors Corp., 11 BRBS 134 (1979) addresses an ALJ's decision to refuse to consider evidence
[105] EX-3 p.74
[106] EX-6 p.5
[107] EX-3 p.30
[108] PX-13
[109] EX-2 p.3

While an argument could be made that Claimant should have been able to accept Employer's June 2001 invitation to return to light duties, Doctor Margiotti's testimony placing 12 weeks as the maximum recovery period with minimal, if any, residual impairment clearly establishes that Claimant reached maximum medical improvement and his work related disability ended by no later than 19 Aug 01.

Although it would be reasonable to expect that in the course of 12 week period leading up to total recovery, there would be a point at which Claimant's condition would justify partial rather than total disability, there is no specific evidence on this issue. As a result, the totality of the evidence establishes total disability from the date of the injury until the maximum recovery period 12 weeks later.

FACTUAL CONCLUSIONS

Based on the above I find that in the course of his employment on 19 Apr 01, Claimant sprained his ankle. He did not injure his knee or back on that date. Any disability he suffered due to said sprained ankle was resolved by 19 Aug 01. If he could not or would not return to work after that date, it was not due to any injury suffered in the course of his employment. I further find that neither Employer nor Carrier were aware of Claimant's treatment by Doctor Phillips until after the surgery. I also find that the provision of the records in the course of the civil law suit did not constitute sufficient notice such that Employer could have been determined to have refused such treatment.

ORDER AND DECISION

Based upon my review of the entire record and consistent with the foregoing findings of fact, conclusions of law, and analysis, I enter the following decision and order.

Claimant's claim is granted in part, denied in part.

1. Employer shall pay Claimant compensation for temporary total disability from 19 Apr 01 to 19 Aug 01 based an average weekly wage of $710.68 at the time of injury.[110]

2. Employer shall receive credit for all compensation heretofore paid, as and when paid.

[110] 33 U.S.C. § 906(b)-(c)(2001)

3. Employer shall pay interest on any sums determined to be due and owing at the rate provided by 28 U.S.C. § 1961 (1982). [111]

4. Claimant's attorney shall have thirty days from the date of service of this decision by the District Director to file a fully supported fee application with the Office of Administrative Law Judges; a copy must be served on Claimant and opposing counsel who shall then have twenty days from date of service to file any objections thereto.[112]

So ORDERED.

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PATRICK M. ROSENOW
Administrative Law Judge

[111] Effective February 27, 2001, this interest rate is based on a weekly average one-year constant maturity Treasury yield for the calendar week preceding the date of service of this Decision and Order by the District Director. this order incorporates by reference this statute and provides for its specific administrative application by the District Director. Grant v. Portland Stevedoring Co., et al., 16 BRBS 267 (1984).

[112] Counsel for Claimant should be aware that an attorney's fee award approved by an administrative law judge compensates only the hours of work expended between the close of the informal conference proceedings and the issuance of the administrative law judge's Decision and Order. Revoir v. General Dynamics Corp., 12 BRBS 524 (1980). The Board has determined that the letter of referral of the case from the District Director to the Office of the Administrative Law Judges provides the clearest indication of the date when informal proceedings terminate. Miller v. Prolerized New England Co., 14 BRBS 811, 813 (1981), aff.d, 691 F.2d45 (1st Cir. 1982). Thus, Counsel for Claimant is entitled to a fee award for services rendered after 24 Sep 03, the date this matter was referred from the District Director.